December | 14

The National Disability Insurance Scheme – National means National

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A JacksonRyan Challenge Paper

An Explanation

This document comprises three separate papers. Each has direct implications for the National Disability Insurance Scheme (NDIS).

The purpose of the three papers is to bring to the discussions about the NDIS considerations that go beyond the operational activities as occurring in the trial sites.

The papers incorporated in this document are:

Paper 1 – A Fully National System

Paper 2 – Safeguards and the National Disability Insurance Scheme

Paper 3 – Quality Assurance – More than A Checklist Approach

The reason why the three papers have been developed is because of the writers' concerns in relation to the current discussions about the future directions and development of the Scheme.

The writers argue that unless due consideration is given to the issues addressed through each of the three papers, the outcomes arising from what is possibly being considered in relation to each may increase the risk of the NDIS being encumbered with expectations and functions which are not in keeping with its basis as an insurance scheme, and which will threaten its sustainability.

Note:
The writers base their view on their long-term involvement and knowledge of Victoria's disability sector and the reasonable assumption that undue consideration is being given to what is operating in Victoria is promoted as being a 'cure-all'. The writers have also closely monitored papers that have been made public, as well as commentary associated with the NDIS.

Paper No. 1

A Fully National System

Introduction

The writers argue the first order of business that must be addressed as part of any deliberations of the Council of Australian Governments (COAG) and its Ministerial Disability Reform Council are the following.

- **The NDIS as an Insurance Scheme**
- **The NDIS as a National System**
- **A Separation of Powers and Responsibilities**

While it should not be necessary to highlight that the NDIS has been established as an insurance scheme and that it is intended to be a nationwide scheme, it seems clear from some of what has been written and spoken in relation to quality assurance and safeguards, for example, that these two critical factors have either been ignored or forgotten.

Therefore, unless due consideration is given to the scheme being an insurance scheme as well as it being a national scheme, then it seems reasonable to conclude that the outcomes of deliberations as to what should constitute particular activities and authorities of the National Disability Launch Transition Agency (NDIA, the Agency) post the three-year trial period, will compromise the legislative authority invested in the National Disability Insurance Scheme Act 2013 (the Act) and the intent forged by the Productivity Commission.

1. A National scheme – A National Approach

Thus, the following addresses what the writers contend are matters that should be critically considered in order to inform the current thinking associated with the full rollout of the NDIS.

(i) The NDIS as an Insurance Scheme

Object 3 (1) (b) of the Act clearly states that object as being to “provide for the National Disability Insurance Scheme in Australia.” The traditional concept and definition of “insurance” is one of transferring risk of a loss to the insurance company in exchange for payment by the insured. In the case of the NDIS the premium is paid from taxes collected.

Therefore, the NDIA as the body responsible for managing the insurance scheme on behalf of governments is equivalent to an insurance company. People with disabilities who are assessed as being eligible to receive a benefit from the insurance company, in the form of funds to meet their reasonable and necessary supports, are the main beneficiaries of the insurance scheme. Nonetheless, all Australians under the age of 65 are covered by the scheme and as such are potential beneficiaries of the scheme.

As such, the NDIA is neither the equivalent of a government department responsible for the provision of disability services nor a watchdog - it is an insurance company. It is in the business of insurance, albeit that the Insurance Scheme it is responsible for can comprise services and activities that are in the nature of coordination, strategic or referral services activities; funding for persons or entities to enable them to assist people with disabilities to participate in economic and social life; and individual plans which fund reasonable and necessary supports for certain people.

(ii) The NDIS as a National System

As Object 3 (1) (b) of the Act clearly states, the Disability Insurance Scheme is a "National" scheme. Given this, and given the Act is Commonwealth legislation, so it must be that everything associated with the scheme must therefore come under a national umbrella. As such, the writers deplore the concept that has been promoted in relation to standards, where it has been suggested that all that is required of the various jurisdictions is that standards developed by them must be "nationally consistent". Such a concept is not consistent with the notion of a national scheme. There must be only one set of standards applying to the providers of disability services.

The requirement for “national” rather than “nationally consistent” must also apply to:

- Accreditation/registration
- Standards & Quality Assurance
- Safeguards & Inspectorial System
- A Complaints mechanism
- Advocacy

(iii) A Separation of Responsibilities and Authorities

Associated with the above is that the elements as identified must come under the jurisdiction of a single national body, and this body must be separate from and independent of the NDIA.

The role and responsibilities of the NDIA must not be compromised by seeking to make it an, "all things to all people” type entity. The NDIA must be allowed to do its work without being loaded down by being required to also function as an auditor, advocate, service reviewer, receiver of complaints and policeman.

The concept of a separation of powers must be applied to the NDIA and a separate body established, as in a national body, to take responsibility for and to have the authority to act in relation to the elements identified in (ii) above. It will only be through the establishment of such an entity that people with disabilities as consumers, their families and the general public will be confident that the functions as described above are truly independent of the NDIA.

It is reasonable to suggest that in Victoria consumer and public confidence in disability services is at its lowest ebb since the establishment of the Intellectually Disabled Persons Services Act in 1986. In part, this is as a result of the Yooralla rapes and the failure of the Department of Human Services and watchdog entities to actually do their job of protecting the rights of people with disabilities to be able to live free of abuse, neglect and exploitation. Therefore, to have state entities maintaining a presence or involvement in a National scheme, either by way of maintaining state jurisdictional control or by a process of transplanting what currently exist in those jurisdictions is untenable.

As an example, the writers suggest that consideration be given to something akin to that as described and as diagrammatically represented below.

Name: National Disability Compliance Authority (NDCA)

Purpose: To uphold the rights of persons with disabilities to high quality supports and to live free from abuse and neglect, exploitation and violence, by having sole authority and responsibility for:

- Accreditation/registration
- Monitoring standards and quality assurance
- Accrediting and monitoring funded advocacy organisations
- Operating a national complaints mechanism, and
- Establishing and implementing an inspectorial system.

Jurisdiction: All entities and individuals across Australia who are credited and registered to provide services and supports to people with disabilities.

Structure: As represented by the diagram below

Notes:

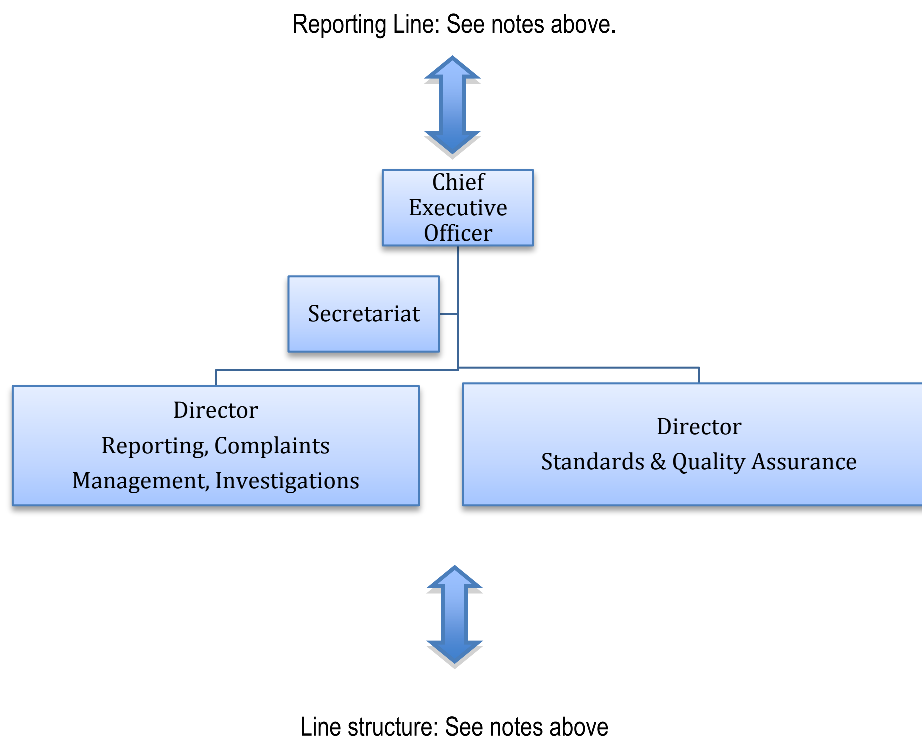
Location and Reporting

Principal options include: (i) location in the Australian Human Right Commission with reporting to the Disability Commissioner; (ii) located in the Department of Social Services reporting directly to the Minister; (iii) a stand-alone Authority. The writers preferred option is (i)

Structure Below Director Level
Principal options include: (i) Provision of a contract function for delivery of the two directorate functions in each of the seven jurisdictions, but independent of the jurisdiction governments. (ii) Each of the three directorates represented in each of the seven jurisdictions. **The writers preferred option is (i)**

Secretariat
A group of support staff to facilitate the functions of the NDCA

Reporting Line: See notes above.



Line structure: See notes above

2. Failed Systems and Processes

The positive rhetoric promoting the effectiveness of state-based systems, certainly from Victoria's perspective, is akin to an advertising campaign by those who hold positions of power and authority. Indeed, it could well be argued that by promoting more of the same in terms of the NDIS people are seeking to maintain their place in the sun through the NDIS.

The reality is the systems and processes that have now been operating in Victoria for several years are simply not working, despite good intentions. For example, despite the introduction of a Disability Services Commissioner (DSC) seven and a half years ago, the role has not fulfilled the expectations of those who make complaints. The reality is that the DSC has not used those powers that exist in legislation. DSC processes are elongated and unnecessarily complex and the focus in on compromise rather than consequences.

In terms of service auditing, despite the Department of Human Services (DHS) having introduced a costly auditing regime, as undertaken by independent companies, it is reasonable to conclude this process is little more than a 'tick the box' exercise. Therefore, it has done little to truly test whether services managed by DHS as well as those funded by DHS are meeting the standards that are required to be met. It must also be noted that DHS has consistently refused to release the audit reports and thus transparency as to outcomes is totally absent.

The Community Visitors program that operates under the Public Advocate, while having had some import in identifying what they describe as systemic neglect and abuse, in reality they have no authoritative power. Also, other than calling for an inquiry, the Public Advocate has failed show initiative in pursuing systemic concerns through her office.

Although the Secretary of DHS has significant powers under the Disability Act 2006 as associated with funding, monitoring, evaluating, reviewing and contracting disability services, as well that having lead responsibility for administering the Disability Act, it is reasonable to conclude these functions and responsibilities have not been exercised to a level that satisfies the expectations of people with disabilities and their families as well as the general public.

3. Concluding Comment

The writers urge those who will make the final decisions in relation to the critical elements of standards and quality assurance and safeguards and associated functions not to take the easy way out.

Clearly, the easy way out would be to simply transplant that which currently exists in particular jurisdictions, albeit with some minor changes to the systems and process which operate at a jurisdictional level.

It is therefore critical that senior bureaucrats in state and territory-based departments, Disability Service Commissioners and Public Advocates are not given the inside running in seeking to influence the directions of the NDIS and as applying to standards, safeguards, and service monitoring consequences when failures to meet required standards and statutory obligations are identified.

Given that the NDIS and its operational arm, the NDIA, represent the most significant initiative, as applying to disabilities, ever taken by any government in Australia's history, it is therefore crucial that the next steps should not be based on more of the same, particularly where "the same" has clearly not worked.

The writers again urge COAG and Senator Fifield to cast off the shackles of the sameness of conservatism, and to be bold in establishing a truly national system that is focused on outcomes and not simply the inputs of yesterday.

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Paper 2

Safeguards and the National Disability Insurance Scheme

Introduction
If the safeguards that will operate under the National Disability Insurance Scheme (NDIS) are to provide a truly effective protective framework, then discussion on this subject must go beyond the myopic view currently being expressed by some.

For example, it is all too convenient to simply consider what is currently occurring in the various states where there is an existing complaints mechanism established under the jurisdiction of a Disability Complaints Commissioner or equivalent, or look at those elements of disability legislation that relate to safeguards, and to suggest or assume these provide an effective framework.

While much has been written about rights, as applying to people with disabilities, including the right to be safe and live free from abuse and neglect, it is essential to explore in greater depth what this actually means in the context of safeguards. Or, in other words - What is it that the safeguards are seeking to protect? If we are clear as to what it is we are seeking to "safeguard" then we will be in a better position to be able to articulate the mechanisms best able to do this.

If there are existing mechanisms that should be considered as possibly being part of the new safeguard regime then they should not be accepted at face value simply because they exist at the moment. It is essential they are subjected to critical analysis in terms of how effective they are, or have been; and further whether or not they fit into the concept of a national framework.

The underlying thesis of this paper is that simply transferring what currently exists in particular jurisdictions, even with some fiddling around the edges, is not appropriate. The concept of a holistic and single national system must be applied.

As such, this paper explores the following:
- The concept of safeguards and the four-elements of a safeguard system
- Current deficits
- The NDIS and a single system

What do we mean by safeguards?
Although different interpretations may exist as to what is meant by safeguards, the writers submit that it is unarguable that in the context of people with disabilities they must be:

> ***Measures that are established and actions applied to uphold the rights of people with disabilities, to protect them from harm and to prevent something undesirable happening to them.***

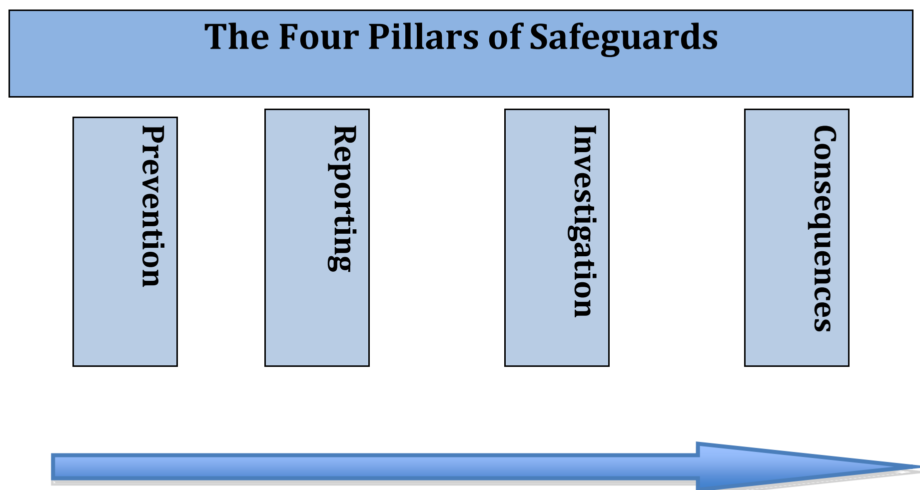
Thus, safeguards must be about protecting people with disabilities from neglect, abuse, violence and exploitation. Given this, it must also be recognised that neglect, abuse, violence and exploitation can come in many forms and can be perpetrated either as a direct action, or by contrast an inaction, by a person or entity charged with providing a duty of care to person with a disability.

Given the duty of care imperative, it therefore stands to reason that safeguards must, at the very least, include preventative measures. However, no matter how stringent preventative measures might be, their effectiveness cannot be totally guaranteed. Therefore, safeguards must go beyond preventative risk management.

Thus, while the first element of a safeguard system is that of risk prevention strategies, other strategies must also form part of an overall safeguards system. Further detail is provided below in relation to what are described as the four pillars of safeguards. These four pillars should be considered as applicable to the NDIS as well as any other disability system.

1. The four elements of a safeguard system

Given that prevention must be the first pillar in a safeguard system, what then are the other pillars and what measures or activities must be incorporated into each of the four pillars identified in the diagram below?



(i) Prevention

Much that has being written about safeguards as well the actual safeguards that have been put in place has tended to focus on the reporting of incidents and complaints. While acknowledging that complaints reporting and management and incident reporting are integral to a safeguards hierarchy, nonetheless the first pillar must be prevention.

As the old adage goes "prevention is better than cure". This adage could have no greater applicability than in the disability sector and as relating to the prevention of neglect, abuse and violence towards people with disabilities. As already noted above, while there is no guarantee that any preventative strategy will necessarily always work, the basic assumption must be that if the strategies are operationally sound, and applied at all times, it is more likely than not that they will work.

Therefore, there are a number of preventative strategies that must be written into any future safeguard document. And further, these must be mandated as an automatic requirement and therefore not subject to "ifs, buts or maybes". Certainly, while there is evidence to suggest that some of these preventative strategies currently exist, we know that they have not always worked. In part the reason for this is that they have not necessarily been in inculcated into the culture of disability services.

It is concerning that the concept of duty of care is not written into Victoria's Disability Act. Nor has it been given any prominence by entities such as the Public Advocate, the Disability Services Commissioner or service providers, including DHS. Therefore, it is reasonable to suggest that neither the legal nor moral obligations associated with duty of care have been given priority in the provision of services to people with disabilities.

Although not necessarily exhaustive the following are submitted as constituting the elements of the prevention pillar:

- Applying the rules of effective recruitment and staff selection including advertising widely, ensuring clarity of roles and responsibilities for the positions being recruited, undertaking a thorough selection process
- Applying pre-employment checks including referee, police checks and any necessary medical clearances
- Instituting detailed induction/orientation programs, preferably undertaken prior to a new staff working with clients
- Establishing a "buddy system" whereby new staff work alongside experienced, longer term staff in the initial phase of employment

- Applying a probationary period and ensuring that appropriate reviews are undertaken during the course of the probation
- Not allocating a new staff member to a lone roster position until, and unless, there is absolute satisfaction as to the person's knowledge and abilities
- In the event of serious issues or concerns arising during the period of the probation, applying its terms of employment by discontinuing the employment of the staff person
- Implementing regular performance reviews which include the staff member's knowledge of his or her position, assessment of his or her operational performance, and assessment of his/her knowledge of relevant legislation and policies and procedures
- Ensuring on-the-job day-to-day performance management including role modelling by more experienced colleagues and spot checks
- Having available mandatory in-house training and development programs
- Rotating staff through various programs or rosters in order to ensure they establish a broad understanding of the service in which they are employed, and also to avoid what might be called the "ownership" syndrome developing, whereby individual staff establish a belief they actually "own" the client, the roster or the program.

In addition to the above, the one critical preventative element is that of effective and regular supervision, whereby this includes role modelling, observation and immediate remedial action if required. Associated with the matter of effective supervision is ensuring that supervisors, particularly those involved in direct service to clients, actually undertake the task of supervision and are not, either as a result of organisational requirements or of their own volition, tied up in bureaucratic processes and locked away in the office doing paperwork.

Further on the matter of supervision, there must also be the requirement for middle level managers to regularly observe the practices of their line reportees and base grade staff in the operational environment. In other words, they must place themselves in a position of knowing what is going on.

(ii) Reporting

Victoria has long had an incident reporting system established under the authority of the Department of Human Services (DHS) and as applied to services managed by DHS as well as agencies funded by that department. In terms of complaint mechanisms, the creation of the Disability Services Commissioner under the Disability Act 2006 established a complaints process managed by that office. This was extended to what might be called 'internal complaints' within service agencies, whereby all registered service providers are required to have a complaints mechanism and are required to report annually to the Disability Services Commissioner in relation to the complaints managed by them.

Essentially, incident reporting to the Department and the submission of complaints to the Disability Services Commissioner are both forms of reporting. In effect, incident reporting is primarily an internal process; whereas the making of complaints, as applying to the Disability Services Commissioner, is an external process

Despite incident reporting having been place for approximately a quarter of a century, and the Disability Service Commissioner having operated since mid-2007, there is clear evidence to suggest that these processes have not been effective in stemming the tide of neglect, abuse and violence in the disability sector in Victoria. Evidence of this in part resides in articles in The Age and the recent ABC Four Corners program (24/11) which highlighted significant abuse, including rapes, in one of Victoria's largest and highest-funded disability service providers. The evidence also resides in the recent call as made by Victoria's Public Advocate in the 2014 Annual Report of Community Visitors, that abuse and neglect is systemic across the disability accommodation sector and has not only been reported by Community Visitors over a number of years but it is growing.

The evidence also resides in the fact that prior to its election the newly elected government in Victoria announced its intention to undertake a broad-based inquiry into the disability sector. And further, the evidence resides in the fact Victoria's Ombudsman has also recently

announced an inquiry. Therefore, while it is important to acknowledge the existence of incident reporting and complaints management, given this indisputable evidence the question must be asked – Why have reporting safeguards failed?

There are several factors why incident reporting and the complaints management process have been relatively ineffective as stand-alone safeguards in reducing the actual and potential likelihood of incidents, including abuse and neglect, occurring.

In terms of incident reporting it is reasonable to suggest this process has not been as effective as it should have been as a protective measure largely due to the following:

- Not all incidents which should be reported are reported or are readily available; noting Community Visitors in Victoria were highly critical in their 2014 annual report of the failure of incidents to be reported or reports to be available during their visits
- The content of incident reports lacking clarity and not providing all the information as required
- There is an absence of timely follow-up in relation to the incidents being reported
- There is a failure of management to use incident reports as a management tool to identify potential systemic issues, training needs or individual staff incompetence
- Incident reports are not promoted with emphasis given to their being a mandated requirement
- Incident reports are not linked to quality assurance provisions and performance management, noting that the former Minister responsible for disability in Victoria requested the Disability Services Commissioner monitor and review incidents involving staff to client assault and unexplained injury. However, other than report on themes in his 2014 Annual Report, the Disability Services Commissioner provided no analysis of the reports in terms of how incidents related to legislative or process failures and did not note any links to quality assurance provisions.

In terms of complaints management it is reasonable to suggest the reason why this process has not been as effective as it should have been as a protective measure is largely due to:

- The processes adopted by Victoria's Disability Services Commissioner have been unnecessarily complex and elongated
- Victoria's Commissioner has established a mantra whereby he considers failures in communication as the basis for complaints and therefore the establishment of more effective communication is the answer to reducing complaints
- In effect this attitude denies the existence of neglect, abuse and violence as being the real basis for particular complaints submitted to him
- Despite the Commissioner reporting each year that complaints have not been resolved or were only been partially resolved, in some instances the Commissioner closed these cases
- Despite the Commissioner having investigative authority under the Disability Act, he has consistently refused to undertake investigations of those complaints which have either been deemed not suitable for conciliation or where conciliation has failed
- Despite the Commissioner's advice that a number of complaints relate to the failure of service providers to meet their legislative responsibilities, the Commissioner has failed to report on such legislative failures in his annual reports
- The Commissioner has also failed to name, in his annual report, those organisations that have not met their legislative obligations, and/or the number of complaints made against individual organisations

Therefore, if reporting through incidents reports and the lodgement of complaints are to part of a new safeguard model, although not necessarily exhaustive, the following are submitted as constituting the elements of the reporting pillar:

- Mandatory Reporting as applies for child protection
- Mandated Incident Reporting for all registered providers
- A complaints mechanism
- The requirement of all reports to include:
    - The detailed nature of the incident or complaint, including dates/times/location

- Identification of all entities or individuals involved
- Details to whom the report/complaint has been directed and actions taken

(iii) Investigating

Although investigative powers already exist for Victoria's Disability Services Commissioner, as evidenced through his annual reports he has failed to implement even one single investigation since 2009. Equally, although DHS also has the power to investigate allegations of, for example, abuse and neglect or other types of complaints as applying to its own service provision as well as those funded through the department, there is a strong prima facie case to suggest the former Secretary of DHS failed to exercise authority in this regard.

A classic example of the failure of both DHS and a funded agency relates to the review jointly commissioned by DHS and the Yooralla organisation in relation to rapes and associated reporting and follow-up issues that occurred in service outlets operating under the jurisdiction of Yooralla. Despite the obvious necessity for the consultant, who was engaged by DHS and Yooralla to investigate the allegations, an excuse used by both was that the consultant did not interview the complainants alleging that he had been asked not to do so by the police. Subsequently, the police denied this allegation.

The writers argue that even where the police may be involved in investigating allegations, the organisation also has an obligation to conduct its own internal investigations. Not to do so is a clear abrogation of its responsibilities to protect the rights of those people with disability who are supported by the organisation.

Obviously, the importance of the investigative process is to provide opportunity to the complainant as well as the respondent to state their case, and also to seek to determine whether or not the allegations can be substantiated. Substantiation may include witness statements, documented evidence, and observational evidence as in signs of physical abuse and the like. Therefore, not to investigate clearly denies the complainant his or her right to have a complaint addressed in a way that has a greater chance in determining the efficacy or otherwise of the complaint. Indeed, it is argued the investigation of complaints is a protective device for the complainant and also the respondent, with fairness and natural justice being applied to both.

Therefore, it is essential that investigations are considered as a crucial element of a safeguard system. Further, that investigations are not open to the waxing and waning of the individual or entity that has the authority to investigate. It is also equally important that the investigative process is independent of the funder and the service provider. And further, that the outcomes of the investigative process are transparent.

(iv) Consequences

Although there is a range of consequences that can be applied to individuals and entities who fail to meet their service and legislative obligations, it is reasonable to conclude that it is rare for any significant consequences to be applied to individuals and entities who transgress, in a significant way, their service and legislative obligations. A glaring example of this failure is that of the Yooralla rapes.

While it is true that the two rapists were jailed as a consequence of their horrendous behaviour towards people with disabilities in their care, it is essential to note this action did not come about as a result of the Yooralla Board, Chief Executive Officer or indeed DHS taking the initiative to bring these matters to the attention of the police.

That writers are also aware, as a result of their involvement with people with disabilities and their families, of a number of cases where DHS, the Disability Services Commissioner and particular funded agencies have failed, and in some cases refused, to mete out appropriate consequences to staff who failed a duty of care towards those people with a disability in their care.

In terms of individuals who transgress significantly against people with disabilities, a range of options is available to managers. And while acknowledging industrial agreements and

Fairwork requirements may have some import, nonetheless, again it is reasonable to suggest that rarely are any of these options applied. The possible consequences include:

- Charges leading to court action
- Termination
- Demotion
- Monetary fines
- Formal counselling
- Additional training and support

It is all very well to suggest or infer that reporting and a complaints mechanism represent the endpoint of a safeguards process. Along with investigations, the significant gap in the so-called safeguards systems currently operating is the failure of those with the power to do so to vigorously pursue consequences for those individuals who transgress.

2. A New Approach - More than a Transplant or Fiddling Around the Edges

As already expressed in Paper 1 the writers submit that it would be short-sighted of those responsible for establishing the next steps for the NDIS to simply transplant that which is currently operating in particular state or territory jurisdictions, or pretend to establish something new by simply fiddling around the edges.

3. Concluding Comment

The writers can only again emphasise that a truly functional safeguard system must include the elements identified in this paper. They also must again emphasise that the safeguards system that is to be established for the NDIS must be a national system and must be managed at the national level by a national entity.

Nothing could be more foolish than to take that which currently exists in particular jurisdictions and pretend that it is working in the way intended and is therefore appropriate to the needs of a national system.

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Paper 3

Quality Assurance – More than A Checklist Approach

Introduction

Quality Assurance (QA) as a concept and practice first became prominent in product manufacturing. It was introduced as a way of preventing mistakes in the production process or defects in manufactured products. This assisted in minimising complaints from the purchasers of such products, whether distributors or as end sale purchasers. It is also reasonable to suggest that the better the quality in terms of manufacturing consistency and quality the greater the level of confidence by the purchasers.

It is only in relatively recent times that the concept and practice of QA has been widely applied to human services and applied to administrative and procedural activities associated with service delivery. Thus it is that QA has become somewhat of a catch cry in the disability sector. Sadly however, while it is not uncommon for the various disability jurisdictions to be high on the rhetoric of standards and what should constitute benchmark quality inputs, the reality has tended to be that quality assurance has become a tick the box exercise on inputs. Essentially, the focus has been on the administrative process of ticking-off whether or not particular policies and procedures exist as opposed to focusing on the implementation and outcomes for the people the system is designed to service.

In terms of manufacturing, two principles underpin QA. The first is described as 'Fit for purpose', or in other words - Is the content of the QA suitable for the intended purpose? The second is described as 'Right first time', or in other words - Does the QA lead to mistakes and deficits being eliminated? Therefore, how might these two principles be applied to QA in disability services?

1. The QA Components in the Disability Sector

In terms of 'fit for purpose', a QA system for the disability sector must focus on the objectives, in all elements, of services to peoples with disability. Thus, when consideration is given to the myriad of objectives and principles that abound in various pieces of legislation and policy statements, both the standards and the safeguards must address these. This includes the principles as articulated in Section 4 of the National Disability Insurance Scheme Act 2013.

In terms of getting it 'right the first time', given the mounting evidence of widespread abuse and neglect across the whole of the disability sector, it is now imperative that the QA system that is established for the NDIS must get it right the first time. There is no room for experimentation or having multiple systems just so long as they are 'nationally consistent'. The greater the number of jurisdictions establishing their own systems and standards, despite allegedly being 'nationally consistent', the greater the multiplier effect will apply. The QA system that is established for the NDIS must, without and variation or debate, be a single system mandated for all jurisdictions that have signed up to the NDIS.

Therefore, the NDIS QA must not only include a set of standards, but also include the level of adherence to all that goes to make up the elements of safeguards as well as assessing the service input and outputs in terms the customer, or person with disabilities. Assurance of the quality of what is being provided must be judged not on the assurance that a checklist has been completed or that providers simply say standard have been met. The customers or the purchasers of the services, as in people with disability, must determine their satisfaction, or dissatisfaction, with the service quality. The outcomes must not be compromised by the cry for "more money" nor should they be assessed by adjectives or evasive descriptors such as, "high", "good" and "poor". The benchmark standards and compliance requirements must be assessed as either being met or not met in terms of their impact on client outcomes.

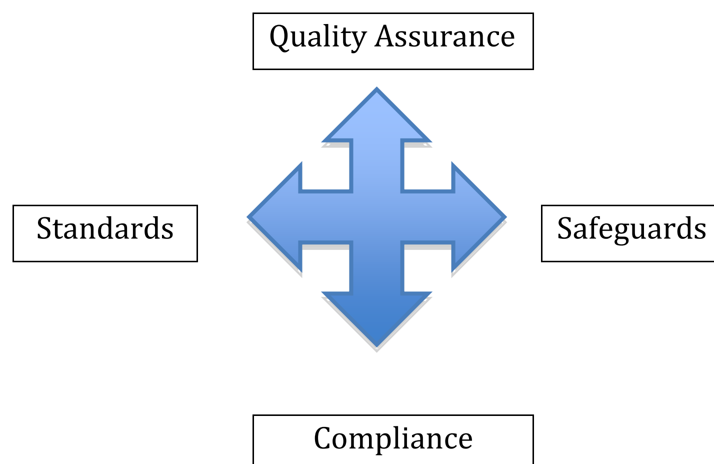
2. QA – A Total System

If quality is to be assured, then it cannot simply be a matter of having a stand-alone set of standards that operate like a checklist that, once ticked off, the assumption can be made that the standards have been met. A set of standards is of course important, and indeed necessary in terms of providing the benchmark against which service delivery and client outcomes can be assessed. Nonetheless, unless there is a marrying of the standards with the safeguards (as detailed in Paper No. 2) and there is compliance against both the standard and the safeguards, quality will not be assured.

Above all else, the purpose of having a QA system is to ensure that the rights of people with disabilities, including their right to be protected from abuse and neglect, is assured to the highest degree possible. Or, in other words, getting it right the first time. By association, the objective of a QA system is to assure that the elements of such a system meet the purpose for which they were designed. That is to assess against the benchmark, which is to provide safeguards and to ensure compliance with both.

It cannot be stressed too strongly that a QA system and process is not simply about the system itself. What it is about is people. That is, people with disabilities. Too often in the disability sector significant effort is put into designing systems and processes and allocating technical and high sounding terminology and then largely ignoring the issue of how best to assess. Too often in the disability sector, despite the rhetoric of rights, the outcomes of the people with disabilities becomes lost in the design process. Therefore, in a word, Quality Assurance in the context of the NDIS must be more than a focus just on the process; it must also focus on the outcomes.

The diagram below provides a schematic view of the link between standards, compliance and safeguards. It identifies Quality Assurance as the overarching structure under which the functional elements of standards, safeguards and compliance operate and are linked.



3. Concluding Comment

While references has been made above to quality assurance coming out of the manufacturing of products and then being adapted to human services, the single most important thing to remember in terms of a QA system for the NDIS, is that we are not talking about widgets, or motor vehicles, or household products - the NDIS is about people, and more importantly about people with disabilities.

Therefore, unlike the potential for product recall in the manufacturing sector if the product is found to be faulty this option is not available in the disability sector. Once damage has been done to people, particularly vulnerable people, then more often than not it cannot be remediated.

If it is that the NDIS QA system is to truly protect people with disabilities there are three critical "must do" requirements.

It must be:

(i) A single National system without any opportunity for individual jurisdictions to impose their own options whether allegedly "nationally consistent" or not.

(ii) A composite system that links standards, safeguards and compliance.

(iii) A single national system that imposes uncompromising consequences on those providers who fail to meet the Quality Assurance requirements.

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